FORM 221

**UTAH LABOR COMMISSION**
PO BOX 146610, SALT LAKE CITY, UT 84114-6610
(801) 530-6800 (800) 530-5090 FAX: (801) 530-6804

# Restorative Services Authorization/Denial

| Patient's Last Name: | First: | Middle: | Referring Physician: | Date of Injury: |
|---|---|---|---|---|
| | | | | |

| Social Security Number: | Date of Birth: | Height: | Weight: |
|---|---|---|---|
| | | | |

| Employer: | Employer Address: |
|---|---|
| Phone: FAX: | |

| Insurance Carrier: | Provider: |
|---|---|
| Address: | Address: |
| | Provider Discipline: ☐ MD ☐ DO ☐ DC ☐ PT ☐ OT |
| Adjuster Name: | Tax ID Number: |
| Phone: FAX: | Phone: FAX: |

| Phone: FAX: | Other Conditions or Complicating Factors that May Affect Recovery: |
|---|---|
| Diagnosis Specific to Industrial Claim: | |

| List from the patient's essential job functions, measurable objective requirements needed to return to work without restrictions (i.e. lifting, carrying, grip, reaching overhead, standing or sitting duration, bending, etc.):* | Capabilities Recorded on First Visit<br>**Date:** | Capabilities on 8th Visit<br>**Date:** | Capabilities on 14th Visit<br>**Date:** | Capabilities on 20th Visit<br>**Date:** |
|---|---|---|---|---|
| 1. Lifting Capacity Max Lbs. Freq. | Max. Lbs._____ | Max. Lbs._____ | Max. Lbs._____ | Max. Lbs._____ |
| Floor-Waist Max Lbs. Freq. | Max. Lbs._____ | Max. Lbs._____ | Max. Lbs._____ | Max. Lbs._____ |
| Waist-Shoulder Max Lbs. Freq. | Max. Lbs._____ | Max. Lbs._____ | Max. Lbs._____ | Max. Lbs._____ |
| Overhead Max Lbs. Freq. | Max. Lbs._____ | Max. Lbs._____ | Max. Lbs._____ | Max. Lbs._____ |
| Carrying Max Lbs. Freq. | Max. Lbs. ___Ft. __ | Max. Lbs. ___Ft. __ | Max. Lbs. ___Ft. __ | Max. Lbs. ___Ft. __ |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| Hours Required to Work per Shift / Day | Hrs. working / Day | Hrs. working / Day | Hrs. working / Day | Hrs. working / Day |
| Patient's Reported Average Pain Intensity (0 to 10 Scale) | /10 | /10 | /10 | /10 |
| Patient's Reported Average Pain Frequency (% of the Day: 0-10-20-30-40-50-60-70-80-90-100%) | % | % | % | % |

| Treatment Plan: (Visits 1-8, include frequency) ☐ Manual Therapy ☐ Manipulation ADL ☐ FCE Testing ☐ Electrical Stim ☐ Ultrasound ☐ Therapy Exercise ☐ Instruction ☐ Neuromuscular Re-education ☐ Others (List): | (Visits 9-14) | (Visits 15-20) | Visits (21-26) |
|---|---|---|---|
| Expected Number of Visits to Reach Stated Functional Goals: | | | |
| Attended/Prescribed Visits: (Prescribed visits are those that should have been scheduled as per the plan of care.) | | | |
| Provider Comments: | | | |
| Provider Signature:<br>Date: | | | |
| Payor: Approval for Future Visits (Yes – No) ☐ ☐ | (Visits 9-14) ☐ | (Visits 15-20) ☐ | Visits (21-26) ☐ |
| Payor Signature:<br>Date: | | | |
| Payor Comments: | | | |

*Please refer to the back section for specific instructions on the completion of the form.

**Treatment Goals as it Relates to the Essential Job Functions:** Use specific, functional, and measurable terms (pounds, degrees of motion-passive and active, hours, minutes, etc.) to describe tasks that the patient needs to perform in order to return to his or her current position or to maximal residual function whenever this is not possible. Towards that end, clinicians should identify those essential job functions that currently limit the client's ability to perform his or her usual duties. These essential job functions must be derived from the client's current job description. Clinicians are encouraged to discuss the physical demands of the position with both the client and the employer. The job description should then be compared to the client's current physical demands in order to identify the essential job functions that will be used as goals to ascertain whether or not the client is making acceptable progress with the treatment being given in returning to work. The goals should be described in objective, measurable and functional terms. Examples include: 1) "occasional lifts of 30 lbs. from floor to shoulder height," 2) "Able to perform light assembly work above eye level for up to 20 minutes at one time and 2½ hours a day," 3) "Able to be up on their feet for up to 2 hours at one time and 6 hours a day," and 4) "Able to type for 45 minutes at one time without increased symptoms." Improvement in stated functional goals, hours worked, and subjective pain ratings will be used to determine whether or not further treatment will be authorized.

**Hours Required to Work Per Shift / Day:** This should reflect the pre-injury average hours required per shift the patient was required to work for a full days work. On the 8th, 14th and 20th visits, list the average numbers of hours a day the patient is currently working.

**Pain Intensity:** Clients should rate their pain on a 10 cm. Visual Analog Scale with "0" = no pain and "10" = the worst pain imaginable.

**Pain Frequency:** Clients should rate what % of the day their pain is present, i.e. 0-10-20-30-40-50-60-70-80-90-100% of the day.

**Expected Number of Visits to Reach Stated Goals: Provider is to estimate from their experience treating patients with a similar condition, the number of visits to obtain the treatment goals.**

**Treatment Plan:** General description of the intended plan of care for the patient. Changes to the program should be noted on the 8th, 14th and 20th visits requests for authorization.

**Attended/Intended Visits:** The number of visits that patient has attended divided by the number of visits the patient should have attended according to the treatment plan. In other words, if the patient should be receiving treatment three times a week but has only attended 4 times in the past three weeks, the result would be 4 (visits attended)/9 (visits intended).

**Provider Comments:** Space is provided for the clinician to provide additional information regarding the patient not covered by previous sections.